Patient Registration

PATIENT INFORMATION

Last Name (Legal)	First Name (Legal)	Middle Initial	Preferred Name (Optional)

Date of Birth	Social Security #	Marital Status	Gender at Birth
		Single Married Widowed Partner Divorced/Separated	Male Female

Street Address (with Apt. # if applicable)	PO Box	City	State	Zip Code

Home Phone #	Cell Phone #	Employment Status	Employer Name
Appointment Reminder Preference: Phone Call / Text Message		Full Time, Part Time, Disabled, Retired, Unemployed, Student, Military - Active Duty	Employer Phone #

Email Address (Required for Patient Portal access)	Preferred Pharmacy

Race	Gender Identity	Sexual Orientation	Are you a migrant or seasonal agricultural worker?	Ethnicity
White	Male	Straight or Heterosexual	Yes No	Hispanic/Latino
American Indian/Alaska Native	Female	Lesbian, Gay or Homosexual		Not Hispanic/Latino
Asian	Transgender Male (M to F)	Bisexual	**Are you a US Veteran?**	**Primary Language Spoken**
Black/African American	Transgender Female (M to F)	Something else	Yes No	English
Native Hawaiian	Other	Don't know	**Are you homeless?**	Spanish
Other/Pacific Islander	Choose not to disclose	Choose not to disclose	Yes No	Other ________
				Interpreter Needed

INSURANCE INFORMATION (We will need a copy of your insurance card(s))

Primary Health Insurance	**Secondary Health Insurance**
Health Insurance Company	Health Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) Spouse Parent Other ________	Policy Holder's relationship to Patient (if different from Self) Spouse Parent Other ________
Primary Dental Insurance	**Secondary Dental Insurance**
Dental Insurance Company	Dental Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) Spouse Parent Other ________	Policy Holder's relationship to Patient (if different from Self) Spouse Parent Other ________
Primary Vision Insurance	**Secondary Vision Insurance**
Vision Insurance Company	Vision Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) Spouse Parent Other ________	Policy Holder's relationship to Patient (if different from Self) Spouse Parent Other ________

EMERGENCY CONTACT (Must be someone other than yourself)

Emergency Contact Name	Phone #

Relationship to Patient? Spouse Parent Child Other ________

Patient Registration

PrairieStar Health Center

GUARANTOR INFORMATION (Financially Responsible Individual)

Guarantor is: Patient is Guarantor (***No need to complete the rest of this section***)
Person Company

Patient's relationship to Guarantor
Child Parent Spouse Employer Other ______

First Name	**Middle Initial**	**Last Name**	
Social Security #	**Date of Birth**	**Gender** Male Female	
Address	**City**	**State**	**Zip Code**

Home Phone #	**Cell Phone #**	**Work Phone #**

Email Address	**Employer Name**

HOUSEHOLD INCOME GUIDELINES

PrairieStar Health Center (PrairieStar) is a Federally Qualified Health Center (FQHC). We receive federal funding and grants. As part of this funding, we are required to collect income data on all patients at least once a year. This data is used to set up programs to meet our patient's needs. Patients must be re-certified on or before their sliding fee anniversary date to receive a discount for services.

PLEASE SELECT THE INCOME THAT BEST DESCRIBES YOUR SITUATION

Number in Household	1	2	3	4	5	6	7	8
Annual Income Under	$12,490	$16,910	$21,330	$25,750	$30,170	$34,590	$39,010	$43,430
Annual Income Between	$12,491 $18,735	$16,911 $25,365	$21,331 $31,995	$25,751 $38,625	$30,171 $45,255	$34,591 $51,885	$39,011 $58,515	$43,431 $65,145
Annual Income Between	$18,736 $21,857	$25,366 $29,592	$31,996 $37,327	$38,626 $45,062	$45,256 $52,797	$51,886 $60,532	$58,516 $68,267	$65,146 $76,002
Annual Income Between	$21,858 $24,980	$29,593 $33,820	$37,328 $42,660	$45,063 $51,500	$52,798 $60,340	$60,533 $69,180	$68,268 $78,020	$76,003 $86,860
Annual Income Over	$24,981	$33,821	$42,661	$51,501	$60,341	$69,181	$78,021	$86,861

PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION (Optional)

I authorize PrairieStar to share my personal health information with the person(s) below. I understand this authorization is **VOLUNTARY.** I understand that once my information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand that this consent will remain in effect until I cancel it in writing.

Name	**Relationship to Patient**	Health Info Billing Scheduling All
Name	**Relationship to Patient**	Health Info Billing Scheduling All
Name	**Relationship to Patient**	Health Info Billing Scheduling All

PAY AGREEMENT

I agree to promptly and fully pay any charges for services I receive at PrairieStar. I understand I will be responsible for any charges not paid by my insurance. I understand I am responsible to check with my insurance provider to see which services are covered. I understand that delinquent accounts are subject to collection activity, including referral to a collection agency.

EXTERNAL PRESCRIPTION HISTORY

PrairieStar uses an electronic health record system that allows electronic prescribing of medications. Medications are sent to the pharmacy through a secure electronic prescription connection which improves the timely and accurate transmission of medication information. I agree that PrairieStar may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. ***By initialing the box, I DO NOT authorize PrairieStar to request prescription medication history.***

ASSIGNMENT OF BENEFITS

I hereby assign and authorize direct payment to PrairieStar of all insurance payments or other third party payers.

CONSENT FOR TREATMENT

I hereby request and give consent for the healthcare professional at PrairieStar to provide medical, dental, vision and behavioral health treatment to me and/or my family.

AUTHORIZATIONS TO RELEASE INFORMATION

I authorize PrairieStar to release any health information that may be necessary for either medical care or for processing of insurance benefits.

I request payment of authorized Medicare/Medigap/Medicaid benefits to PrairieStar and authorize release of health information necessary for processing insurance benefits to Centers of Medicare and Medicaid and other insurance agents.

I hereby certify that the above information is true, and that I have read, fully understand, and accept all terms of the foregoing guidelines.

SIGNATURE OF PATIENT OR GUARANTOR	**DATE**

Patient Registration

PrairieStar Health Center

NON-COVERED SERVICES & CO-PAY

As your medical provider, our relationship is with you and not your insurance carrier. PrairieStar will file your claims to your insurance; however, **you are the sole responsible party for all charges that remain after insurance payments.** Failure to provide PrairieStar with current, accurate insurance information will result in all charges becoming the responsibility of the patient/responsible party. **All co-pays, co-insurance, and sliding scale nominal fees are due prior to services being rendered.** These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. For patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. If we are not contracted with your insurance company, you will be 100% responsible for the payment at the time of service.

PAYMENT ARRANGEMENTS

PrairieStar wants to work with you to meet your healthcare needs at affordable costs. Please contact the patient account representatives at (620) 663-8484 if you need to set up payment arrangements for your account balance. PrairieStar accepts payments in the office, over the phone, on the Patient Portal, or online at https://www.prairiestarhealth.org. For your convenience, you can also set up an automatic/recurring ACH agreement.

NON-PAYMENT FOR SERVICES

If no payment or payment arrangement has been made with PrairieStar after 90 days from the first statement date, your account will be turned over to an outside collection agency. All patients turned to an outside collection agency are required to make either a $75 payment (**this is in addition to any co-pays, co-insurance, and sliding scale nominal fees**) at the time of service for all future appointments until the collection balance has been paid in full or set up an automatic/recurring payment agreement with the Business Office via checking, savings, or debit/credit card.

RETURNED CHECKS/ACH

PrairieStar charges a **$30 fee for all checks and $15 fee for all ACH transactions returned** as non-sufficient funds. The original payment amount, as well as the returned check/ACH fee, will be added to your next statement balance. Checks/ACH's will no longer be accepted on your account and all future payments must be made by cash, debit/credit card, or money order.

SLIDING FEE SCALE

PrairieStar offers a sliding fee scale to all income eligible uninsured or under-insured patients and I acknowledge that I was offered the opportunity to apply. This program allows qualifying patients to receive medical, dental, and vision care at a lower cost. Eligibility for the sliding fee scale will be established by determining the household size and the annual combined household income. Valid proof of income includes: two (2) most recent paystubs, most recent annual federal income tax return, documentation of government assistance, disability determination with benefit amount, documentation of child support/alimony, letter from employer on employer letterhead signed and dated by a supervisor, or financial award letter showing grants, scholarships, or fellowships. If the patient declares no income, then the patient can apply for a 90-day, no verifiable income slide. If a patient chooses not to provide the required information, then he/she will not receive discounted rates offered through the sliding fee scale.

Sliding fee scale eligibility is for the duration of one (1) year. Patients are required to re-certify on or before the sliding fee anniversary date and are responsible for providing current proof of income in order to receive a discount. If you are unable to provide proof of income at the time of application, you will have **14 days from the appointment date**, to submit any proof of income in order to backdate any charges.

APPOINTMENT POLICY

If you are **5 minutes late** for an appointment, you may have to be rescheduled. Your provider will attempt to work you back into the schedule, but this may be after your scheduled appointment time. If we are unable to work you in, you will have to be rescheduled, and this will count as a *missed appointment without notice*. If you miss **two (2)** scheduled **dental** appointments within a **12 month period of time** without notifying PrairieStar prior to the previous business day, you will be notified via letter that you have been placed on **same-day scheduling**.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY

PrairieStar participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or healthcare operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive healthcare services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state healthcare provider regarding those rules.

PATIENT ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

I acknowledge that PrairieStar has provided me with a copy of its Notice of Privacy Practices, which describes how health information about me may be used and disclosed, and how I can access this information. I have been given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that PrairieStar reserves the right to change the terms of this notice periodically, and that I may contact PrairieStar at any time to obtain the most current copy of this notice.

I hereby acknowledge that I have read, fully understand and accept all terms of the financial guidelines and policies stated above.

SIGNATURE OF PATIENT	DATE